DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445098	A. BUILDING _____ B. WING _____	08/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, KNOXVILLE	609 EAST EMERALD AVE KNOXVILLE, TN 37917

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and facility policy review, the facility failed to administer/and or withhold medication as ordered by the physician for one (#13) of four residents with blood pressure parameters reviewed. The findings included: Resident #13 was admitted on December 11, 2013, with diagnosis including End Stage Renal Disease on Hemodialysis, Hypertension, Diabetes, Congested Heart Failure, Atrial Fibrillation, Abdominal Aortic Aneurysm, Alzheimer's, Dementia with Behaviors, Myocardial Infarction, Anxiety, and Depression. Medical Record Review of the Minimum Data Set (MDS) dated July 11, 2014, revealed resident #13 was moderately cognitively impaired and required extensive assistance for activities of daily living. Observation of resident #13 on August 6, 2014, at 3:30 p.m., in the resident's room revealed the resident sitting in a wheelchair with head in hand, alert, oriented to self only. Continued observation	F 309	This Plan of Correction is submitted as required under State and Federal Law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity of regarding any of the deficiencies cited are correctly applied. F 309 1 The resident (#13) has received their additional hypertension medication as ordered. 2 I reviewed our MAR system (IMAR) and was able to look at all the residents who are on PRN anti-hypertensive medications to ensure BPs were documented and parameters followed. No other residents were found to be affected. 3 100 % of the nurses have been in-serviced by the DON on the importance of following ordered parameters associated with medication administration. In-services conducted starting August 27 and concluded with-in two weeks. 4 The DON or ADON or either RCC will monitor the Medication Administration Records. The results of the monitoring will be reported to the QA Committee consisting of the Administrator, DON, ADON, Social Worker, Activities, Dietitian and Medical Director. The ADON will report these results at the QA meeting on September 5.	9/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] Beau Stivason	Administration	9/28/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 revealed the resident was confused and not able to engage in a simple conversation. Medical record review of a physician's order dated May 6, 2014, revealed "...Clonidine 0.1 mg (milligram) tablet...Give 1 tablet by mouth three times daily if systolic >155, diastolic >95..." (Clonidine is a medication to treat high blood pressure [BP] and the number on top is the systolic and the bottom number is diastolic.) Medical record review of the Medication and Treatment Administration Record Reports dated June, July and August 2014, revealed the following blood pressure results and if Clonidine 0.1 mg was administered: June 1: 10 a.m. (130/68) 10 p.m. (133/92) June 2: 10 p.m. (117/73) June 3: 10 a.m. (153/79) June 4: 10 a.m. (138/68) 10 p.m. (154/84) June 5: 10 a.m. (148/74 10 p.m. (121/70) June 6: 10 a.m. (128/70) 10 p.m. (153/86) June 7: 10 p.m. (137/75) June 8: 10 p.m. (134/86) June 9: 10 p.m. (117/70) June 10: 10 a.m. (136/74) 10 p.m. (138/72) June 11: 10 p.m. (111/67) June12:10 p.m. (132/80)	F 309		

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F 309	Continued From page 2 June 13: 4 p.m. (138/80) June 14: 10 a.m. (138/60) 4 p.m. (130/58) June 15: 10 a.m. (138/76) 4 p.m. (132/66) 10 p.m. (143/79) June 17: 10 a.m. (120/54) 4 p.m. (124/66) 10 p.m. (132/68) June 18: 4 p.m. (136/68) 10 p.m. (134/52) June 19: 10 a.m. (142/74) 4 p.m. (132/62) 10 p.m. (153/69) June 20: 4 p.m. (138/74) 10 p.m. (138/54) June 21: 10 a.m. (148/80) 4 p.m. (136/74) June 22: 10 a.m. (150/83) 4 p.m. (138/76) June 23: 4 p.m. (154/78) 10 p.m. (110/70) June 24: 10 p.m. (132/71) July 1: 10 a.m. (152/89) 2 p.m. (139/84) 10 p.m. (130/78) July 2: 2 p.m. (138/76) Clonidine 0.1 mg was omitted on the following dates: July 5: 10 a.m. (153/99) July 10: 10 p.m. (160/90) July 17: 10 p.m. (168/94)	F 309		

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F 309	Continued From page 3 July 20: 10 p.m. (167/82) July 24: 10 a.m. (163/84) August 3: 10 a.m. (158/98) August 4: 10 p.m. (175/92) Interview with the Physician on August 6, 2014, at 9:50 a.m., at the 3rd floor nursing station confirmed the Clonidine order was a PRN (as needed) order with blood pressure parameters necessary before administering the medication. Interview with Licensed Practical Nurse (LPN #3), on August 6, 2014, at 4:36 p.m., in the Director of Nursing's (DON) office, confirmed LPN (#3) administered the Clonidine and was not administered in accordance to the prescribed parameters. Interview with the DON on August 6, 2014, at 4:30 p.m., in the DON's office confirmed resident #13 received Clonidine forty-four times in error when the resident's Blood Pressure (BP) did not meet criteria to administer the medication and the resident did not receive Clonidine seven times when the BP parameter required administration. Further interview with the DON confirmed the facility had failed to administer the antihypertensive medication according to the parameters prescribed by the Physician 51 times in 57 days.	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 4 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, medical record review, and interview, the facility	F 431	F 431 1. For residents 300, 202 and 116 (along with all other residents in the facility) the medication room was cleaned and all clutter removed. Temperature logs were placed on each medication refrigerators. The nursing staff reviewed each medication cart and separated oral from topical medications. The medications that were from discharged patients were all logged and destroyed on site. Narcotic logs and Narcotic inventory sheets were updated and reconciled. In the medication room, the two handbags were locked up, the bag of soda cans were thrown out into the dumpster, house-keeping washed the sink and the insect company we use sprayed for the ants. 2. Other residents receiving topical, oral medications and narcotics have the potential to be affected by this practice. As outlined in #1 above, the medication room was cleaned, temperature logs placed, oral and topical medications were separated, all d/c'd medications logged and destroyed and narcotic logs reconciled. Personal belongings (handbags) were locked up and Sprayed for ants. 3. 100 % of the nursing staff have been in-serviced by the DON on the importance of keeping the medication room clean and free of clutter, notification to housekeeping supervisor for the presence of insects, following procedures with monitoring and recording of refrigerator temperatures, keeping topical and oral medications separate, logging of narcotics and destruction of non-controlled medications in accordance to our medication disposal policy. In-services conducted starting	9/15/14

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F 431	Continued From page 5 failed to maintain a clean, clutter free medication room for one of one medication rooms reviewed; failed to monitor and maintain temperature logs for one of one medication refrigerators; failed to properly store topical wound and oral medications; failed to dispose of expired medications; failed to store and dispose of medications for twenty-three discharged residents; failed to reconcile the Narcotic Inventory Record Log and the Narcotic Inventory Record for four of twenty- five narcotic medications reviewed. The findings included: Review of facility policy, Medication Storage in the Facility, revealed "Medications and biologicals are stored safely,..properly...(c) Orally administered medications are kept separate from externally used medications...(k) Medication requiring refrigeration...between 2 degrees C (36 degrees F) and 8 degrees C (46 degrees F) are kept in a refrigerator...to allow temperature monitoring...(n) Medication storage areas are kept clean, well-lit and free of clutter and extreme temperatures...(o) Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified..." Review of facility policy, Disposal of Medications, Syringes, and Needles, revealed, "...When medications are discontinued...resident is...discharged...the noncontrolled medications are marked as 'discontinued' and are to be destroyed..." Paragraph (a) "...Medications awaiting disposal are stored in a...area designated for that purpose until destroyed... (b...medications...are destroyed in accordance with the destruction policy and	F 431	August 27 and concluded with-in two weeks. 4. The DON or ADON or either RCC will monitor the medication room for cleanliness, presence of insects, temperature logs, medication carts for appropriate separation of topical vs oral medications, routine destruction of d/c'd medications and narcotic log review. This will continue for the next three months.The results of the monitoring will be reported to the QA Committee consisting of the Administrator, DON, ADON, Social Worker, Activities, Dietitian and Medical Director. The ADON will report these results at the QA meeting on September 5. Monitoring will continue weekly in October, then every two weeks in November.	

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F 431	Continued From page 6 procedure...medications left in the facility after a resident's discharge...are destroyed..." Observation of medication cart #2 on August 5, 2014, at 2:46 p.m., in the northwest hall on the 3rd floor revealed a 16 ounce bottle with approximately 14 ounces remaining of Hysept Solution 0.25% (percent) Sodium Hypochlocite Solution (used in the treatment of wounds) stored in the bottom drawer of medication cart #2 along side bottles of oral medications. Continued observation revealed a 10 ounce bottle with approximately 6 ounces remaining of Geri-Mucil, Sugar Free Fiber Laxative with a manufacturer's expiration date of April 2014 in the bottom drawer. Interview with Licensed Practical Nurse (LPN #3) on August 5, 2014, at 2:55 p.m., in the northwest hallway of the 3rd floor confirmed a 16 ounce bottle of Hysept Solution 0.25% Sodium Hypochlocite Solution was stored in the bottom drawer of medication cart #2 next to oral medications. Further interview with LPN #3 confirmed the manufacturer's expiration date was April 2014. Observation on August 5, 2014, at 3:25 p.m., in the 3rd floor medication room revealed the following: ants crawling in and on the sink; the sink drain covered with a thick, black residue; one garbage bag full of empty soda cans on the floor, and two handbags on the floor. Interview with LPN #3 on August 5, 2014 at 3:26 p.m., in the medication room with confirmed the ants in the sink, the sink was dirty, and the floor was cluttered with a garbage bag of empty soda cans and personal belongings.	F 431		

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F 431	Continued From page 7 Observation on August 5, 2014 at 3:30 p.m., in the medication rooms revealed no temperature log on the medication refrigerator. Interview with the Assistant Director of Nursing (ADON) on August 5, 2014 at 3:32 p.m., in the medication room confirmed no temperature monitoring log on the medication refrigerator documenting daily temperatures. Observation on August 6, 2014 at 3:30 p.m., in the secured medication room revealed a clear plastic garbage bag in the cabinet under the sink, under a box of resident alarms containing 861 oral medications, as follows: 2 vials of vitamin B12 unopened, intravenous antibiotics, unopened, 28 inhalation solutions, and 1 vial of insulin improperly stored. Medications were dated from October 2013 through July 2013 for 23 discharged residents. Continued observation revealed the following classifications of the medications: antiarrhythmics; antianxiety; antianginals; antihypertensives; antiulcer; antiplatelets; antidepressants; antigout; antilipemics; antipsychotics; antirheumatic; anticonvulsants; antibiotics; antimalarials; anticoagulants; antiemetics; antitussives; antialzheimer; corticosteroids; diuretics; hemostatics; inotropes; iron supplements; non-steriodal antiinflammatory drugs; potassium supplements; skeletal muscle relaxants; thyroid hormones; urinary antispasmodics; vitamins/mineral supplements. Interview with the ADON on August 5, 2014, at 3:45 p.m., in the medication room confirmed the clear plastic garbage bag of medications was improperly stored and was to be destroyed. Further interview with the ADON confirmed the	F 431		

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F 431	Continued From page 8 medications had not been timely destroyed and "...the medications should have been destroyed in thirty days..." Interview with the Director of Nursing (DON) on August 6, 2014, at 3:15 p.m., in the conference room confirmed the medications for discharged residents were not destroyed in a timely manner. Observation of medication cart #1 on August 5, 2014, at 3:05 p.m., on the 3rd floor revealed four of twenty-five Narcotic Inventory Record Logs did not reconcile with the Narcotic Inventory Record for Lortab 7.5 mg, 30 tablets for resident #300; Lortab 7.5 mg, 30 tablets for resident #202; Lortab 5.0 mg, 30 tablets and Ativan 0.5 mg 30 tablets for resident #116. Continued observation revealed six of six medication carts reviewed for narcotic counts were accurate. Interview with the DON on August 6, 2014, at 1:30 p.m., in the DON's office confirmed no further Narcotic Inventory Records were found for residents #300, #202 and #116. Interview with the Pharmacist on August 6, 2014, at 2:00 p.m., in the conference room confirmed medication audits were performed monthly. Continued interview revealed the facility had a documentation and filing problem. Further interview confirmed no documentation for the destruction of the Narcotic Inventory Record's for residents #300, #202, and #116 could be found. Further interview revealed letters of inspection were sent between February 2014 through July 2014 notifying the facility of incorrect narcotic log and inaccurate documentation. Interview with the DON on August 6, 2014, at	F 431		

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F 431	Continued From page 9 3:15 p.m., in the conference room confirmed the Narcotic Inventory Record Logs were unable to be reconciled with the Narcotic Inventory Records for resident #300, #202, and #116.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	F 441 1. No patients were harmed by this practice. 2. Every Geri-chair and wheel-chair were checked and cleaned as needed so that no other areas of patient concern were noted. 3. 100 % of the nursing staff has been in-serviced by DON on the importance of proper hand hygiene when providing patient care. In-services conducted starting August 27 and concluded with-in two weeks. Housekeeping and Maintenance implemented deep cleaning of all wheel-chairs and Geri-chairs which started Sep. 1. 4. New procedures implemented: Housekeeping and Maintenance department will conduct a deep cleaning at least 1 time per month for chairs available. The nursing department will inspect all chairs on a daily basis (after residents put to bed) and do cleaning as necessary. Administrator will monitor compliance and report to QA on September 5. Administrator will monitor wheelchair weekly progress for 4 weeks, then monthly until 100% compliance. DON or designee will monitor hand hygiene with medication pass and routine patient care at least weekly for September or until 100% compliance is noted. Findings for initial week will be reported at September5 QA.	9/15/14

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F 441	Continued From page 10 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure staff washed hands after contact with residents and prior to medication administration for one of three nurses observed and failed to maintain the cleanliness of one of six geri-chairs observed. The findings included: Observation on August 4, 2014, at 6:02 a.m., in the 200 hallway revealed Registered Nurse #5 (RN) answered a personal alarm in room #205. Continued observation revealed RN #5 repositioned the resident, stopped the alarm, and readjusted the linen on the resident's bed. Continued observation revealed RN #5 exited the room, returned to the medication cart, and resumed the medication administration for another resident without disinfecting the hands. Review of facility policy, Handwashing, revealed, "...1. When to wash hands...f. Before and after caring for each patient. g. During medication pass..." Interview with RN #5 on August 4, 2014, at 6:20 a.m., in the 200 hallway, confirmed the RN had not disinfected hands after direct contact with a resident, prior to resuming medication administration for another resident. Observation on August 5, 2014, at 7:55 a.m.,	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445098	A. BUILDING _____ B. WING _____	08/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, KNOXVILLE	809 EAST EMERALD AVE KNOXVILLE, TN 37917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 revealed a geri-chair in the hall between rooms 262 and 265 in the 200 hall with dust build up with stain and spill marks on the seat and on the left side of the chair, under the armrest. Interview with Licensed Practical Nurse (LPN) # 6, designated as the facility's Infection Control Nurse, in the conference room hall on August 5, 2014, at 9:37 a.m., revealed there was no policy for cleaning of the wheelchairs or geri-chairs. During interview, LPN # 6 stated, "The wheelchairs and geri-chairs are cleaned thoroughly twice a year in the spring and fall and, if necessary, cleaned in the shower if soiled or on an [as needed] basis." Interview with LPN # 1 in 200 hall on August 5, 2014, at 8:07 a.m., confirmed the geri-chair in the 200 hall was used for residents and when asked when the chair would be cleaned, LPN # 1 stated "before I use it." Interview continued and LPN # 1 stated, "housekeeping is responsible for cleaning the chair and the person using the chair should clean it if it gets soiled before putting it back." Further interview with LPN # 1 revealed, "it (the geri-chair) is really dirty." Interview with CNA # 6 in 200 hall on August 5, 2014, at 8:16 a.m., confirmed the chair is used for residents "don't have their own to go to other areas in the facility." Interview continued and CNA # 6 stated "it is filthy..."I think that housekeeping cleans them."	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 12 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of Quality Improvement (QI) sign-in sheets and minutes, and interview, the QI Committee identified a problem and failed to develop and implement a plan of correction for controlled drug irregularities. The findings included: Review of QI sign-in sheets and concurrent interview with the Help Information Manager, on August 6, 2014, at 4:35 p.m., in the Medical	F 520	P 520 1. The DON used the same documents that the surveyors used (per NHC policy) to ensure that no residents harmed by this issue. 2. No other areas of patient concern were identified. 3. A formal process and procedure for monitoring of narcotic usage and documentation have been developed. 100% of nursing staff have reviewed this procedure through in-services by the DON starting August 27 and concluded with-in two weeks. 4. A Quality Improvement Plan has been written up and will be reported to the QA Committee consisting of the Administrator, DON, ADON, Social Worker, Activities, Dietitian and Medical Director. The ADON will report these results at the QA meeting on September 5. Monitoring will continue weekly in October, then every two weeks in November.	9/15/14

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F 520	Continued From page 13 Records office revealed the Pharmacist last attended the QI meeting on October 25, 2013. Further review of the October 2013 minutes revealed "...controlled drug irregularities...including signed out, not documented as given. 196 doses audited, 165 doses documented as given. Plan of correction created..." Continued interview revealed no further documentation of the controlled medication irregularities "...it's a nursing issue..." Interview with the Director of Nursing (DON), on July 6, 2014, at 5:00 p.m., in the DON's office, confirmed the facility had failed to develop a plan of correction for controlled drug irregularities.	F 520		